Arts Academy Charter Middle School

Student Health Information Update 2019-2020

Student: ____DOB___________ Grade: ___
Last Name First Name MI

Address____

Mother's/Guardians Name________________________ Home Phone Number ___________________

Cell Phone Number_____________________

Father's/Guardians Name__________________________ Home Phone Number ___________________

Cell Phone Number___________________

1. Has your child been hospitalized? No_____ Yes______ Year________

Reason____

2. Other than well-visits, is your child under a doctor's care now? No_______ Yes______

Reason____ Where ____________________

3. Does your child need a special diet or have a food problem? No________ Yes______

Give details: ____

4. Is your child allergic to some foods? No _______ Yes_______

List: ____

Will your child require emergency medication if this food is touched/ingested? No_____ Yes_____

If yes to #4 and or #5, please contact the nurse's office at extension 517 for special forms.

5. Does your child have any health problems or special health needs about which the school should be aware?

No______ Yes_____ Please list medical and psychological concerns.

List: ____

____

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6. Apart from vitamins, is your child taking any over-the-counter or prescription medications on a regular or as needed basis? No______ Yes______

List: ____

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7. Does your child need to take any medications at school? No_____ Yes_____ (such as inhaler/epi-pens/prescription meds/over the counter meds. etc...)

List: ____

<u>If yes, please contact the nurse's office 517 for special forms.</u>

8. Does your child have any restrictions of physical activities? No_____ Yes_____

If yes, describe____

A doctor's note is required for any restrictions.

9. Is your child allergic to medication: No________ yes________

List: ____

10. Is your child allergic to insect bites/stings: No______ Yes______

List: ____

Will your child require emergency medication if stung or bitten by this insect? No ______ Yes______

<u>If yes, please contact the nurse's office at extension 517 for special forms.</u>

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In case of an emergency, I give / do not give permission for my child to be transported to

_______________________________ and for their staff to provide the necessary treatment until I arrive.
Name of Hospital

Health Insurance: ____________________________________ Policy/ ID#________________________

Physician Name: _____________________________________ Phone#: (____) ________________________

Your signature on the document indicates that the information provided is accurate. Additionally, by signing below I give my permission for the school nurse to share health information with appropriate staff, and if necessary contact my child's primary care provider for the health and safety of my child.

______________________ ____

Date **Signature**

This form is kept on file in the Health Room